DELAWARE HEALTH AND SOCIAL SERVICES
Division of Long Term Care Residents Protection

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STATE SURVEY REPORT

NAME OF FACILITY Ingleside Homes **DATE SURVEY COMPLETED:** March 21, 2017

SECTION	STATEMENT OF DEFICIENCIES Specific Deficiencies	ADMINISTRATOR'S PLAN FOR CORRECTION OF DEFICIENCIES WITH ANTICIPATED DATES TO BE CORRECTED
	An unannounced annual and complaint survey was conducted at this facility beginning March 9, 2017 and ending March 21, 2017. The facility census on the entrance day of the survey was 51 residents. The survey sample totaled eight residents and was composed of 5 residents plus a subset of three residents. The survey process included observations, interviews and review of resident clinical records, facility documents and facility policies and procedures. Abbreviations used in this state report are as follows: **ED - Executive Director** **DON - Director of Nursing** **RN - Registered Nurse** **LPN - Licensed Practical Nurse** **CNA – Certified Nurse Aide** **UAI – Uniform Assessment Instrument - an assessment form used to collect information about the physical condition, medical status and psychosocial needs of an applicant/resident in order to determine eligibility for an assisted living facility.** **Service Agreement – the organization of services developed by the resident and facility to meet the needs of the**	**3225.8.1.1** 1. Unable to retroactively correct deficient practice for resident (RSS3). Resident's medication refills were verified as up to date as of 03/19/17. 2. All Residents have the potential to be affected by this deficient practice. Systems changes listed in section 3 will correct for any potentially affected residents. As of 03/31/17, physician orders were verified against MAR for all residents during MAR change-over. MARs were then verified against available medications during the routine pharmacy delivery. No additional residents were affected by this deficient practice. 3. System Changes: a. The DON in-serviced all licensed nursing staff (LPN's) on how to exactly read and prepare prescribed Polyeth Glyc 3350 NF (Miralax) powder utilizing dosage inscribed measuring cup that accompanies medication bottle as of 03/30/17. b. The DON in-serviced all licensed nursing staff to check each shift resident medication supplies and order accordingly from pharmacy; re-ordering of all powder and/or liquid medications when medication bottle become ½ full in prevention of disruption of resident

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	resident identified in the UAI. **3225.0** **Assisted Living Facilities** **3225.8.0** **Medication Management** **3225.8.1.1** **An assisted living facility shall establish and adhere to written medication policies and procedures which shall address:** **This requirement is not met as evidenced by:** Based on observation and staff interview it was determined that the facility failed to ensure that a prescribed medication was refilled and available for administration as prescribed by her physician for one resident (RSS3) out of eight residents sampled. Findings include: During observation of the administration of medication on 3/17/2017 at 9:00 AM E5 (LPN) began to prepare the prescribed medication, "Polyeth Glyc 3350 NF Powder (Miralax Powder/used to treat occasional constipation), mix 17Grams in 8 ounces of water daily once daily", for RSS3 and realized that the quantity of the medicated powder remaining in the bottle measured less than 17 grams. After checking the medication cart without locating another bottle labelled with the above referenced medication for RSS3, E5 stated apparently the medication had not been refilled. This finding was reviewed with E1 (ED),	medication regime as of 03/30/17. c. 8 ounce drinking cups immediately added to facility house stock list to ensure in stock availability at all times. d. Orientation program for licensed nurses shall be amended to include a skills verification (observation) on how to refill orders as well as medication preparation for administration. 4. Impact of the system changes: a. Prevention of future medication omissions and errors by ensuring residents receive proper medication dosage(s). b. The DON will conduct random observations of at least two nurses on three different occasions within 1 month with goal of 100% compliancy to conclude problem is resolved by 06/23/17. c. The evaluation date and any follow up shall be forwarded to the ED within 5 business days of observation. d. Upon review of audits the ED and DON will determine need for any further tracking. **3225.8.8.2**

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	E2 (DON) and E3 (Owner) on 3/21/2017 at approximately 4:20 PM.	1. Facility cannot retroactively correct deficiency for resident (RSS1). RSS1's medication refills were verified as up to date as of 03/19/17.
3225.8.8	**Concurrently with all UAI-based assessments, the assisted living facility shall arrange for an on-site medication review by a registered nurse, for residents who need assistance with self-administration of or staff administration of medication, to ensure that:**	2. All Residents have the potential to be affected by this deficient practice. System changes listed in section 3 will correct for any potentially affected residents. As of 06/23/17, the DON observed and monitored three consecutive medication passes of licensed nursing staff (LPNs). No additional residents were affected by this deficient practice.
3225.8.8.2	**Each resident receives the medications that that have been specifically prescribed in the manner that has been ordered;**	3. System changes:
	This requirement is not met as evidenced by:	a. All licensed nursing staff (LPN's) in-serviced on how to utilize premeasured dosage cap that accompanies Polyeth Glyc 3350 NF (Miralax) bottle for proper medication administration.
	Based on observations and staff interviews it was determined that the facility failed to ensure that the administration of a medication was consistent with the physician's order and medication was available for administration as prescribed by the physician for two residents (RSS1 and RSS2) out of 8 residents sampled. Findings include:	b. All LPN's in-serviced on the five rights of medication administration with emphasis on correctly reading medication bottle against MAR for preparation and/or administration directions.
	1. Observation of the administration of medication conducted on 3/17/2017 at 9:00 AM revealed that E5 (LPN) failed to create the correct mixture of a prescribed medication and water for administration to RSS1 in accordance with the physician's order. Review of the Medication	c. 8 ounce drinking cups immediately added to facility house stock list to ensure in stock availability at all times. 4. Impact of the system changes:

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	Administration Record (MAR) dated 3/2017 and the medication label revealed consistency in the medication ordered and the amount of liquid needed to prepare the mixture. The medication label read "Polyeth Glyc Pow 3350 NF (Miralax Powder/used to treat occasional constipation), Mix 17 gms (gram: a unit of measure) in 8 ounces of water and drink by mouth once daily." During preparation of the mixture E5 measured the powder in the medication cap specifically designed for this purpose. Next she poured the medication powder into a plastic cup and filled the same cup with an amount of water she assumed equaled 8 ounces. Observation of the cup revealed the absence of any markings for accurate measurement. In an interview with E2 (DON/RN) conducted on 3/17/2017 at approximately 11:30 AM this surveyor was informed that the plastic cup used by E5 to fill with water and the medication powder was actually a 5 ounce cup. E2 further stated that the 5 ounce cup size was the only cup supplied to the nursing units and confirmed that the 5 ounce cups lacked markings for accuracy in measurement. These findings were reviewed with E1 (ED), E2 (DON) and E3 (Owner) on 3/21/2017 at approximately 4:20 PM. 2. During observation of a medication administration conducted on 3/17/2017 at	a. The DON shall observe and monitor three consecutive medication passes of licensed nursing staff (LPN's) with goal of 100% compliancy to be achieved to conclude problem is resolved by 06/23/17. b. The evaluation date and any follow up shall be forwarded to ED within 5 business days of the observation. c. All audit information will be forwarded to QI via the Executive Director (ED). The ED will evaluate the information and present it to the QI committee. d. Upon review of the audits, the QI committee will determine any need for further tracking. **3225.8.8.2** 1. Facility unable to retroactively correct deficient practice for resident (RSS2). Upon notice of the error on 03/20/17, DON clarified order, faxed order to pharmacy and updated MAR. 2. All Residents have the potential to be affected by this deficient practice. System changes listed in section 3 will correct for any potentially affected residents. As of 03/31/17, physician orders were verified against MAR for all residents during MAR change-over. MARs were then verified against

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	9:00 AM it was revealed that the label of a medication prescribed for RSS2 read "Ventolin HFA Aer (Aerosol) Inhale 2 puffs by mouth every 4 hours as needed". A comparison of the medication label and the MAR (medication administration record) dated 3/01/2017 – 3/31/2017 revealed differences in the frequency of administration of the medication. The MAR read "Albuterol 90 micrograms (mcg)/inhalation (inh) aerosol, 2 puffs every 4 hours (hrs)". A review of the original physician order dated 1/11/2017 revealed that it read "Albuterol 90 mcg/inh (inhalation) aerosol 2 puff inhalation every 4 hours". However the frequency of administration of the inhaler was changed to "every 4 hours as needed (prn)" by the physician and upon the recommendation of the pharmacist on 1/11/2017. This finding was confirmed by E2 (DON/RN) who spoke directly to the pharmacist-in-charge and knowledgeable of the incident on 3/20/2017 at approximately 12:15 PM. Further review of the clinical record also revealed the presence of RSS2's original script dated 1/11/2017 with changes in the frequency of the administration of Ventolin HFA Aer inhaler from "every four days" to "every four hours as needed" with the approval of his physician obtained by the facility pharmacy. A closer review of all MARs dated 3/01/2017 – 3/31/2017 revealed that one of the MARs was labeled "PRN Medications" and included the revised physician order "Ventolin HFA Aer inhale	available medications during the routine pharmacy delivery. No additional residents were affected by this deficient practice. 3. System changes: a. The DON in-serviced all licensed personnel on the 5 rights of medication administration (i.e. correct dose) on 03/30/17. b. During the in-service noted above, the DON addressed pharmacy notification to facility of medical doctor verbal order changes to prescribed medications (i.e. fax notification). c. Effective 3/31/17, 11-7 Nurse to conduct night chart checks for any new orders, verifying and comparing with onsite medications for any discrepancies; if any found seek clarification with pharmacy and/or PCP. 4. Impact of the system changes: a. POS, MARS & medication labels shall reflect the same information. b. Effective 3/31/17, 11-7 Nurse will conduct a weekly medication cart audit. c. DON will conduct an audit to verify POS, MARS & medication labels reflect the same

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	2 puffs by mouth every 4 hours as needed". However the above referenced MAR labeled "PRN Medications" revealed absence of documented medication administrations and the time of administration, indication for use of the medication and effectiveness of the Ventolin HFA Aer inhaler between 3/01/2017 and 3/21/2017. Additionally review of the physician order sheet dated 3/1/2017 revealed a single order for the inhaler, "Ventolin HFA Aer, inhale 2 puffs by mouth every 4 hours as needed...". These findings were reviewed with E1 (ED), E2 (DON) and E3 (Owner) on 3/21/2017 at approximately 4:20 PM	information on 10% of the residents. Supervisory intervention (further training or discipline) shall occur to address deficient practice. This shall continue until the audits are 100% x 3 weeks. d. The evaluation date and any follow up shall be forwarded to ED within 5 business days of the observation. e. Upon review of audits the ED and DON will determine need for any further tracking.
3225.9.7	**The assisted living facility shall have on file evidence of vaccination against pneumococcal pneumonia for all residents older than 65 years, or those who received the pneumococcal vaccine before they became 65 years and 5 years have elapsed, and as recommended by the Immunization Practice Advisory Committee of the Centers for Disease Control, unless specifically, medically contraindicated. All residents who refuse to be vaccinated against pneumococcal pneumonia must be fully informed by the facility of the health risks involved. The reason for the refusal shall be documented in the resident's medical record.** **This requirement is not met as**	**3225.9.7** 1. Facility unable to retroactively correct deficient practice for resident. Will offer vaccination to resident (R3) and/or educate and document about benefits and risks of vaccination if resident refuses. 2. All Resident have the potential to be affected by the deficient practice. a. The DON will audit all current resident records by 06/23/17 for any resident that has not received the Pneumococcal vaccination or does not have documentation of a refusal for vaccination 65 years or older. b. Any resident identified shall be offered the vaccination by

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	evidenced by: Based on clinical record review and staff interview it was determined that the facility failed to document reasons for refusal and discussion of the health risks involving refusal of the pneumococcal vaccine for one resident (R3) out of five sampled. Findings include: Clinical record review revealed that documentation of the administration or refusal of the pneumococcal vaccination for R3 was absent for the year 2016. Additionally the facility failed to document any discussion with R3 regarding the health risks involved due to refusal of the pneumococcal vaccine and to document reasons expressed by R3 for refusal of the pneumococcal vaccine. These findings were reviewed with E1 (ED), E2 (DON) and E3 (Owner) on 3/21/2017 at approximately 4:20 PM.	07/09/17. c. Any of these resident who refuse shall be educated on the risks of refusal and asked to sign waiver form by 07/09/17. 3. System Changes: a. Upon admission the DON will educate the resident regarding Pneumovax benefits and/or possible risks if not receiving the vaccination. 4. Impact of the system change: a. IAL residents will either have evidence of the pneumovax in their chart of a copy of the waiver form indicating the vaccine was offered, refused and that the resident was educated about risks. b. Sample: all new residents to be offered pneumovac upon admission. c. Audit: Executive Director (ED) will review new admissions medical records until three in a row are compliant.
3225.11.0 **3225.11.4**	**Resident Assessment** **The resident assessment shall be completed in conjunction with the resident.** **This requirement is not met as evidenced by:** Based on clinical record review it was determined that the facility failed to complete the Uniform Assessment Instrument (UAI) with dates and signatures for one resident (R1) out of	**3225.11.4** 1. Facility unable to retroactively correct deficient practice for resident (R1). 2. All residents have the potential to be affected by this deficient practice.

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3225.11.5	eight residents sampled. Findings include: Review of R1's initial UAI dated 11/13/2015 revealed the absence of the signature and date signed by the facility Registered Nurse (RN). These findings were reviewed with E1 (ED), E2 (DON) and E3 (Owner) on 3/21/2017 at approximately 4:20 PM. **The UAI, developed by the Department, shall be used to update the resident assessment. At a minimum, regular updates must occur 30 days after admission, annually and when there is a significant change in the resident's condition.** **This requirement is not met as evidenced by:** Based on clinical record review it was determined that the facility failed to ensure that Uniform Assessment Instrument assessments (UAI) were updated annually or 30 days after admission for 4 residents (R1, R2, R3 and R5) out of eight sampled. Findings include: 1a. Review of the clinical record revealed that the facility failed to ensure that an annual UAI assessment was developed for R1 beginning 11/16/2016. Clinical record review revealed that R1 remained without an annual UAI beginning 11/16/2016 and throughout the survey	a. All records shall be audit for status of UAI by 07/24/17. b. Any UAIs not up-to-date will be brought current by 7/24/17. 3. System changes: a. Incomplete UAI are a result of previous DONs failure to complete required documentation. Current DON began employment on 01/31/17. b. DON shall create a tracking document that can be accessed by the ED in the event of extended absence or staff separation from employment. 4. Impact of the system changes: a. UAIs will be completed within required time frames and as needed. b. Sample: New admissions. c. Audit: 1) ED will audit the records of new resident for a completed UAI upon admission and at 30 day until three records in a row are compliant. 2) ED shall check routine tracking document for residents who are due for their annual UAI. ED shall audit these records until there are

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	process ending 3/21/2017. These findings were reviewed with E1 (ED), E2 (DON) and E3 (Owner) on 3/21/2017 at approximately 4:20 PM. 1b. Review of the initial UAI assessment dated 11/13/2015 revealed the absence of an assessment completed within thirty days of the admission of R1 to the assisted living facility on 11/16/2015. These findings were reviewed with E1 (ED), E2 (DON) and E3 (Owner) on 3/21/2017 at approximately 4:20 PM. 2. Review of the clinical record revealed that the facility developed an annual UAI assessment effective 7/1/2015 for R2. However further review of the clinical record revealed the absence of an annual UAI effective 7/1/2016 through 12/31/2016. Additionally clinical record review revealed that R2 remained without an annual UAI beginning 7/1/2016 and throughout the survey process ending 3/21/2017. These findings were reviewed with E1 (ED), E2 (DON) and E3 (Owner) on 3/21/2017 at approximately 4:20 PM. 3. Review of the clinical record revealed that the initial UAI developed for R5 was effective 11/30/2015 through 11/30/2016. However further review of the clinical record revealed the facility failed to complete an annual UAI that was due	three in a row that are compliant. 3) All audit information will be forwarded to QI via ED. The Executive Director will evaluate the information and present it to the QI committee. 4) Upon review of the audits, the QI committee will determine any need for further tracking. **322.11.5** 1. Facility unable to retroactively correct deficient practice for resident (R1). UAI's for this resident will be brought current by 06/09/17. 2. All residents have the potential to be affected by this deficient practice. System changes listed in section 3 will correct for any potentially affected residents. 3. System changes: a. The DON/RN will complete UAIs upon admission, 30 days after initial UAI, annual and if any changes in condition. b. The DON will complete resident (R1) annual UAI by 06/09/17. c. The DON will audit all resident charts compose list of due UAI's for completion.

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3225.12.1.3	12/1/2016. Clinical record review also revealed that an annual UAI was developed for R5 with an effective date of 1/11/2017. These findings were reviewed with E1 (ED), E2 (DON) and E3 (Owner) on 3/21/2017 at approximately 4:20 PM. 4. Review of the initial UAI assessment dated 4/19/2016 revealed the absence of an assessment completed within thirty days of the admission of R3 to the assisted living facility on 5/20/2016. These findings were reviewed with E1 (ED), E2 (DON) and E3 (Owner) on 3/21/2017 at approximately 4:20 PM. **Food service complies with the Delaware Food Code** **This requirement is not met as evidenced by:** **Based on observations and interviews during the tour of the kitchen on 3/13/2017, it was determined that the facility failed to comply with sections: 4-501.13, and 4-601.11 (A) of the State of Delaware Food Code.** **4-5 Maintenance and Operation of microwave ovens:** **4-501.13 Microwave ovens shall meet the safety standards specified in 21 CFR 1030.10 Microwave ovens.** **This requirement was not met as evidenced by:**	d. The DON shall notify said designee of each resident annually to schedule a meeting prior to completing annual UAI. Notification will be sent by U.S Postal Service mail. A copy of the notification letter will be placed in the medical record. 4. Impact of system changes: a. Compliancy with resident UAI. b. The chart entries and letters of receipt shall be audited for 3 months. c. The evaluation data and any follow up shall be forwarded to the ED within 5 business days. d. All audit information will be forwarded to QI via ED. The Executive Director will evaluate the information and present it to the QI committee. e. Upon review of the audits, the QI committee will determine any need for further tracking. 1. Facility unable to retroactively correct deficient practice for resident (R2). UAI's for this resident will be brought current by 06/09/17. 2. All residents have the potential to be affected by this deficient practice. System changes listed in section 3 will

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	1. Observation on 3/13/17 at 10:30 AM revealed that the food preparation microwave plate inside of the microwave was cracked. **4-6 Cleaning food equipment and utensils:** **4-601.11 Equipment, food-contact surfaces, Non-food contact surfaces, and Utensils.** **(A) EQUIPMENT FOOD-CONTACT SURFACES and UTENSILS shall be clean to sight and touch** **This requirement was not met as evidenced by:** 1. Observations on 3/13/17 at 10:45 AM revealed that the ice machine filter was covered in biofilm. **3225.13.0** **3225.13.1** **Service Agreements** **A service agreement based on the needs identified in the UAI shall be completed prior to or no later than the day of admission. The resident shall participate in the development of the agreement. The resident and the family shall sign the agreement and each shall receive a copy of the signed agreement. All persons who sign the agreement must be able to comprehend and perform their obligations under the agreement.** **This requirement is not met as**	correct for any potentially affected residents. 3. System changes: a. The DON/RN will complete UAIs upon admission, 30 days after initial UAI, annual and if any changes in condition. b. The DON will complete resident (R2) annual UAI by 06/09/17. c. The DON will audit all resident charts compose list of due UAI's for completion. d. The DON shall notify said designee of each resident annually to schedule a meeting prior to completing annual UAI. Notification will be sent by U.S Postal Service mail. A copy of the notification letter will be placed in the medical record. 4. Impact of system changes: a. Compliancy with resident UAI. b. The chart entries and letters of receipt shall be audited for 3 months. c. The evaluation data and any follow up shall be forwarded to the ED within 5 business days. d. All audit information will be forwarded to QI via ED. The

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	evidenced by: Based on clinical record review it was determined that the facility failed to ensure that an initial service agreement was complete for one resident (R1) out of eight residents sampled. Findings include: Review of the clinical record revealed that the initial service agreement dated 11/13/2015 and developed for R1 was incomplete and inconsistent with the Uniform Assessment Instrument (UAI) dated 11/13/2015 and without resident specific times for the performance of daily tasks and the identification of appropriate staff for assigned tasks. Additionally the signature and the date signed by the facility Registered Nurse was missing from the above referenced service agreement. These findings were reviewed with E1 (ED), E2 (DON) and E3 (Owner) on 3/21/2017 at approximately 4:20 PM. **The service agreement shall be developed and followed for each resident consistent with that person's unique physical and psychosocial needs with recognition of his/her capabilities and preferences.** **This requirement is not met as evidenced by:** Based on clinical record review, review of facility documents and staff interview it was determined the facility failed to ensure that service agreements were reviewed and revised to address the	Executive Director will evaluate the information and present it to the QI committee. e. Upon review of the audits, the QI committee will determine any need for further tracking. 1. Facility unable to retroactively correct deficient practice for resident (R3). UAI's for this resident will be brought current by 06/09/17. 2. All residents have the potential to be affected by this deficient practice. System changes listed in section 3 will correct for any affected residents. 3. System changes: a. The DON/RN will complete UAIs upon admission, 30 days after initial UAI, annual and if any changes in condition. b. The DON will complete resident (R3) annual UAI by 06/09/17. c. The DON will audit all resident charts compose list of due UAI's for completion. d. The DON shall notify said designee of each resident annually to schedule a meeting prior to completing annual UAI. Notification will be sent by U.S Postal Service mail. A copy of the notification letter will be placed in the medical record.
3225.13.5		

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	potential for falls and actual falls sustained by one resident (R1) out of eight residents sampled with measurable goals and specific interventions. Findings include: Clinical record review revealed R1 had diagnoses that included dementia (a severe state of cognitive impairment characterized by memory loss, difficulty with abstract thinking, and disorientation). Review of the initial UAI (Uniform Assessment Instrument) dated 11/13/2015 revealed that R1 needed observation/standby/transfer assist during toileting, physical assistance for ambulation (wheelchair), and one person physical assist for transfers. The initial UAI assessment dated 11/13/2015 also revealed that R1 was oriented to time, place and person and exhibited short-term memory problems. The section of each of the above referenced UAI assessments labeled "Fall Risk Assessment" revealed that R1 was at risk for falls due to a previous fall sustained in the last 30–180 days. However review of the initial service agreement dated 11/13/2015 revealed that the facility failed to address R1's potential for falls with measureable goals and specific interventions. Review of the clinical review also revealed that the initial service agreement developed on 11/13/2015 failed to include measurable goals and specific interventions that addressed the actual falls sustained by R1. Between 9/19/2016	4. Impact of system changes: a. Compliancy with resident UAI. b. The chart entries and letters of receipt shall be audited for 3 months. c. The evaluation data and any follow up shall be forwarded to the ED within 5 business days. d. All audit information will be forwarded to QI via ED. The Executive Director will evaluate the information and present it to the QI committee. e. Upon review of the audits, the QI committee will determine any need for further tracking. 1. Facility unable to retroactively correct deficient practice for resident (R5). UAI's for this resident will be brought current by 06/09/17. 2. All residents have the potential to be affected by this deficient practice. System changes listed in section 3 will correct for any potentially affected residents. 3. System changes: a. The DON/RN will complete UAIs upon admission, 30 days after initial UAI, annual and if any changes in condition.

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3225.19.6	and 10/24/2016 R1 sustained eight falls. Review of facility incident reports revealed that all falls sustained by R1were unwitnessed and without the assistance of facility staff. Instead facility staff found R1 on the floor after each fall. One of the eight falls required transport of R1 to an acute care facility for further evaluation for a complaint of pain. Further review of the initial service agreement dated 11/13/2015 also revealed that the facility failed to review and to develop specific interventions that addressed falls sustained by R1 between 9/19/2016 and 10/24/2016. **Reportable incidents shall be reported immediately, which shall be within 8 hours of the occurrence of the incident, to the Division. The method of reporting shall be as directed by the Division.** **This requirement is not met as evidenced by:** Based on clinical record review and staff interview it was determined that the facility failed to immediately report the transfer of one resident (R5) out of eight residents sampled to an acute care facility within eight hours to the Division. Findings include: Review of the facility incident report dated 2/5/2017 and timed 6:40 AM revealed that R5 sustained a fall due to dizziness and hit her head on the floor while ambulating to the bathroom. R5 also suffered a hematoma to the back of her head and	b. The DON will complete resident (R5) annual UAI by 06/09/17. c. The DON will audit all resident charts compose list of due UAI's for completion. d. The DON shall notify said designee of each resident annually to schedule a meeting prior to completing annual UAI. Notification will be sent by U.S Postal Service mail. A copy of the notification letter will be placed in the medical record. 4. Impact of system changes: a. Compliancy with resident UAI. b. The chart entries and letters of receipt shall be audited for 3 months. c. The evaluation data and any follow up shall be forwarded to the ED within 5 business days. d. All audit information will be forwarded to QI via ED. The Executive Director will evaluate the information and present it to the QI committee. e. Upon review of the audits, the QI committee will determine any need for further tracking.

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	was sent to an acute care facility for evaluation by her physician. Further review of the facility incident report revealed that the facility failed to report the incident to the Division after R1 was transferred to an acute care facility for evaluation and treatment after a fall. Additionally a review conducted on 3/31/2017 of documents submitted by the facility to the Division revealed the absence of a report of the above referenced incident. These findings were reviewed with E1 (ED), E2 (DON) and E3 (Owner) on 3/21/2017 at approximately 4:20 PM.	**3225.12.1.3** 1. Cracked microwave plate was discarded on 03/13/17. 2. All residents receiving meals have the potential to be affected by this deficient practice. System changes listed in section 3 will correct for any affected residents. There are no other microwaves that could be affected by this deficient practice. 3. System Changes: a. Kitchen staff in-service was held to review Delaware Food Code deficiencies (Equipment, Food-Contact Surfaces, Nonfood Contact Surfaces, and Utensils) on 05/12/17. b. At the end of the in-service, kitchen staff were notified that failure to follow Delaware Food Code will result in supervisory intervention. 4. Impact of system changes: a. The Food Service Director or designee shall inspect the kitchen for cracked microwave plate. b. This inspection will be done weekly during the Food Service Director's regularly scheduled work week. c. All information will be forwarded

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SECTION	STATEMENT OF DEFICIENCIES Specific Deficiencies	ADMINISTRATOR'S PLAN FOR CORRECTION OF DEFICIENCIES WITH ANTICIPATED DATES TO BE CORRECTED
		to QI via the Executive Director (ED). The ED will audit information and present it to the QI committee. d. Upon review of the information, the QI committee will determine any need for further tracking. **4-601.11** 1. Ice machine filter was cleaned on 03/13/17. Preventive Maintenance Company contacted and a re-inspection/cleaning of ice machine was performed on 03/22/17. 2. All residents receiving meals have the potential to be affected by this deficient practice. System changes listed in section 3 will correct for any affected residents. There are no other ice machines that could be affected by this deficient practice. 3. System Changes: a. Kitchen staff in-service was held to review Delaware Food Code deficiencies (Equipment, Food-Contact Surfaces, Nonfood Contact Surfaces, and Utensils) on 05/12/17. b. At the end of the in-service, kitchen staff were notified that failure to follow Delaware Food Code will result in supervisory intervention.

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		4. Impact of system changes: a. The Food Service Director or designee shall inspect the kitchen ice machine filter for any biofilm. b. This inspection will be done weekly during the Food Service Director's regularly scheduled work week. c. All information will be forwarded to QI via the Executive Director (ED). The ED will audit information and present it to the QI committee. d. Upon review of the information, the QI committee will determine any need for further tracking. **3225.13.1** 1. Facility unable to retroactively correct deficient practice for residents (R1). Service Agreement will be brought current by 06/09/17. 2. All residents have the potential to be affected by this deficient practice. System changes listed in section 3 will correct for any affected residents. a. All records shall be audited for status of service agreement by 07/24/17. b. Any service agreements not up-to-date will be brought current by

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		07/24/17. 3. System changes: a. The DON/RN will complete service agreement upon admission, 30 days after initial service agreement, annual and if any changes in condition. b. The DON will complete resident (R1) annual service agreement by 06/09/17. c. The DON will audit all resident charts compose list of due service agreements for completion. d. The DON shall notify said designee of each resident annually to schedule a meeting prior to completing annual UAI. Notification will be sent by U.S Postal Service mail. A copy of the notification letter will be placed in the medical record. 4. Impact of system changes: a. Compliancy with resident service agreement. b. The chart entries and letters of receipt shall be audited for 3 months. c. The evaluation data and any follow up shall be forwarded to the ED within 5 business days.

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		d. All audit information will be forwarded to QI via ED. The Executive Director will evaluate the information and present it to the QI committee. e. Upon review of the audits, the QI committee will determine any need for further tracking. **3225.13.5** 1. Facility unable to retroactively correct the error for resident (R1). DON/RN will review, assess and update R1s service agreement to include fall risk (with fall risk agreement) & measurable goals by 6/09/17. 2. All residents have the potential to be affected. The DON shall complete an audit of available nursing reports/incident reports to identify residents who have had a change in condition/fall. The services agreements for these residents shall be reviewed and updated as needed. 3. System changes: a. The DON shall in-service licensed staff on proper documentation of a Resident fall, which includes the completion of incident report upon at time of incident by 3/30/17. b. Upon notice by direct care staff or upon receipt of incident report the, the DON will review record for LPN

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		follow-up. The DON will evaluate whether a change in condition has occurred & document findings in medical record. If so, the DON will complete an assessment, update the UAI & service agreement if needed. 4. Impact of the system change: a. Service agreements will be up-to-date and accurate. b. Sample: Residents with a change of condition/fall as evidenced by completion of an incident report. c. At the end of the month, the ED will select three resident incident reports. The ED will do a chart audit for documentation of an evaluation or an assessment and updated UAI/Service Agreements when needed. Audits shall continue until there are 9 compliant records in a row. d. All audit information will be forwarded to QI via ED. The Executive Director will evaluate the information and present it to the QI committee. e. Upon review of the audits, The QI committee will determine if any further tracking.

DELAWARE HEALTH AND SOCIAL SERVICES
Division of Long Term Care Residents Protection

DHSS - DLTCRP
3 Mill Road, Suite 308
Wilmington, Delaware 19806
(302) 577-6661

STATE SURVEY REPORT

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SECTION	STATEMENT OF DEFICIENCIES Specific Deficiencies	ADMINISTRATOR'S PLAN FOR CORRECTION OF DEFICIENCIES WITH ANTICIPATED DATES TO BE CORRECTED
		3225.19.6 1. Facility unable to correct deficient practice for Resident (R5). Unable to retroactively file incident reports. 2. All residents have the potential to be affected by this deficient practice. System changes listed in section 3 will correct for any potentially affected residents. At the end of the survey, there were no incidents pending that required reporting to the Division within 8 hours. No additional residents were affected by this deficient practice. 3. System changes: a. The DON in-serviced licensed nursing staff on the Incident report policy, reportable incident filing and use of the reporting software on 03/30/17. b. The DON shall audit daily nursing shift report information to identify any injuries that should have resulted in an incident report. The DON will direct staff to complete any needed incident reports. 4. Impact of the system change: All reportable resident incidences shall be filed with the Division within 8 hours. a. Sample: All incident reports. b. Audit: At the end of each month,

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		the ED will review all incident reports. When an incident report for a reportable incident is found, he will then verify the completion of notification to the Division. This will continue until three (3) reportable incidences are compliant. c. All audit information will be forwarded to QI via the Executive Director (ED). The ED will evaluate audit information and present it to the QI committee. d. Upon review of the audits, the QI committee will determine any need for further tracking.

Provider's Signature Judith A. Kaplan Title Executive Director Date July 05, 2017